MAYO CLINIC

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January 18, 2018

Miss Robin L. LeBeau
[redacted]
Eagle Butte, SD 57625-0188

Dana Erickson, M.D.
Division of Endocrinology/Metabolism
Department of Internal Medicine

RE: Miss Robin L. LeBeau
MC#: [redacted]
DOB:

Dear Miss LeBeau:

It was a pleasure to participate in your care during your recent visit to Mayo Clinic.

Our final diagnoses were:

- Rathke's cleft cyst
- Posttraumatic brain injury
- Multifactorial headache
- Medically complicated obesity
- Partial hypopituitarism

Enclosed is the clinical documentation which summarizes our impressions and recommendations (Erickson, Dana: Jan-12-2018, Jan-10-2018; Benarroch, Eduardo E: Jan-11-2018; Atkinson, John L: Jan-10-2018).

Once again, it was a pleasure to participate in your care. If I can be of assistance in the future, please feel free to contact me.

Sincerely,

Dana Erickson, M.D.

de/kap
Enclosures

12-Jan-2018 - Miscellaneous, Dana Erickson, Endocrinology

CHIEF COMPLAINT/PURPOSE OF VISIT
Review results.

IMPRESSION/REPORT/PLAN
Dr. Atkinson met with the patient. He does not recommend any surgical intervention and avoid it if at all possible. As the Rathke's cleft cyst is unchanged from 2012, I would recommend that perhaps an MRI is repeated in about two years from now. If stable, three years from now. Patient saw Dr. Benarroch in Neurology for the multifactorial headaches. He recommended to discontinue daily use of Tylenol and avoid taking over-the-counter medications for headaches more than twice a week for more than 15 days a month. Continue current dose of topiramate. If overnight oximetry is normal, EEG would be appropriate. Exercise program.

DIAGNOSES
#1 Rathke's cleft cyst
#2 Posttraumatic brain injury
#3 Multifactorial headache
#4 Medically complicated obesity
#5 Partial hypopituitarism

Original: de/jgw
Electronically Signed: 15-Jan-2018 13:23 by D.. Erickson, MD

11-Jan-2018 - Consult, Eduardo Elias Benarroch, Neurology

REFERRAL
Dr Erickson 47946

CHIEF COMPLAINT/PURPOSE OF VISIT
Headache

HISTORY OF PRESENT ILLNESS
I am seeing this pleasant 41-year-old right-handed patient in the presence of her sister for an opinion regarding headaches for which she was previously evaluated by Dr Cutrer in 2017. She is currently taking topiramate 100 mg at night which was be started according to the patient approximate 6-7 months ago upon discontinuation of gabapentin that was previously recommended after Dr Cutrer's evaluation. I reviewed the patient's past medical, family, social history, medications, allergies, recent MRI of the head, and neuro surgical condition Dr. Atkinson.

The patient started developing headache after a fall on her occiput in December of 2015. According to the patient, she developed severe headache associated with appears to be a confusional state with difficulty with language. This prompted a repeat MRI after she has been followed for pituitary mass discovered in 2012. Given the interpretation of the mass had enlarged, she underwent a transsphenoidal surgery in September of 2016. Thiswas complicated with hemorrhage requiring surgical repair. Apparently there was not damaged to the pituitary gland. However, the patient has been followed for secondary adrenal insufficiency following surgery. The patient's headaches occur daily and are typically triggered by bending forward. It is uncertain whether she has documented CSF leak through the transsphenoidal surgical defect. There is no evidence of intracranial hypovolemia on the most recent MRI which shows findings consistent with Rathke's cyst rather pituitary adenoma.

Unfortunately, the patient has continued to take Tylenol daily every day of the week. These make it difficult to for her to tell if topiramate is helping her.

She is undergoing the brain rehabilitation program for was diagnosed of mild cognitive impairment following traumatic brain injury in 2015. She has little limited her physical activities and was told not to fly, I assume because of concerns of any structural cause for the patient's headaches.

She feels tired most of the day and tends to fall asleep spontaneously but apparently was never tested for sleep apnea. It is uncertain whether her cognitive symptoms worsened after she was started on topiramate but this does not appear to be the case.
Family history is remarkable for migraine headache in her mother and brother.

REVIEWED INFORMATION WITH PATIENT AS NOTED ON THE CURRENT VISIT INFORMATION FORM, DATED 10-JAN-2018 AND ON THE PATIENT FAMILY HISTORY FORM, DATED 8-NOV-2016.

CURRENT MEDICATIONS

aspirin [BAYER] 81 mg tablet delayed release 1 tablet by mouth every morning.
Indication, Site, and Additional Prescription Instructions:
Stopped 3/26/2017 preop

cholecalciferol (vitamin D3) 10,000 unit capsule 1 capsule by mouth every week.
Indication, Site, and Additional Prescription Instructions:
Mondays

citalopram [CELEXA] 20 mg tablet 1 tablet by mouth every morning.
Indication, Site, and Additional Prescription Instructions:
in AM

dexamethasone sod phosphate [DECADRON] 4 mg/mL solution 1 mL intramuscular as directed by prescriber.
Indication, Site, and Additional Prescription Instructions:
supply needles and syringes, for emergency use only

hydrocortisone [CORTEF] 10 mg tablet 2 tablets by mouth two times a day as needed.
Indication, Site, and Additional Prescription Instructions:
1 pill in morning, 1/2 pill at 3 pm

magnesium oxide 400 mg tablet 1 tablet by mouth two times a day.

metformin 500 mg tablet sustained release 24 hour 1 tablet by mouth two times a day.

omeprazole 20 mg capsule enteric coated by mouth as needed.
Indication, Site, and Additional Prescription Instructions:
as needed for heartburn

simvastatin 20 mg tablet 1 tablet by mouth every bedtime.

topiramate [TOPAMAX] 100 mg tablet 1 tablet by mouth every bedtime.

Vitamin C 500 mg tablet 1 tablet by mouth two times a day.

These are the patient's medications as of Thursday, 11-Jan-2018 at 02:10.

SYSTEMS REVIEW

CONSTITUTIONAL
Fatigue
SKIN - Negative

EYES - Negative
ENT - Negative
RESP - Negative
CV
    Pain in calves when walking
GI - Negative
MUSCULOSKELETAL - Negative
NEURO
    Pain
    Headaches
HEME / LYMPH - Negative
PSYCH
    Sleeping difficulty
GYN
    Last PAP smear & pelvic exam, < 1 year ago
    History of abnormal PAP
    Last mammogram, < 1 year ago
    Hysterectomy
    G1 P1
GU - Negative
ENDO
    Unusual thirst
COMMUNICABLE DISEASE - Negative
MALE
OTHER SYMPTOM(S) NOT LISTED - None
ALLERGIC / IMMUN
    See Allergies Screen
    See Immunizations Screen

PAST MEDICAL/SURGICAL HISTORY

MEDICAL HISTORY
    Diabetes
    High cholesterol
    Asthma
    Veins
    Blood transfusion - not answered,
SURGICAL HISTORY
    Neck
    Brain
    Uterus
    Ovaries
    Tubes
    Hysterectomy

SOCIAL HISTORY

SOCIAL HISTORY
    Relationship status - Single
    Employment status - Unemployed
    Feel afraid in own home - No
    Fearful for own safety - No
HABITS
    Tobacco - current use - No, I quit all use,
    Tobacco - quit 4-10 years ago

FAMILY HISTORY

FATHER

Father alive
Heart disease High cholesterol Arthritis Alcohol abuse Drug abuse
MOTHER
Mother alive
Breast cancer Ovarian cancer Migraine headache Stroke/TIA High cholesterol Arthritis
BROTHERS
High cholesterol Alcohol abuse Drug abuse
SISTERS
2 sisters alive
High cholesterol Drug abuse

GRANDPARENTS
Pancreatic cancer Alcohol abuse

PHYSICAL EXAMINATION

Neuro mental status examination revealed some difficulty with attention and slowness of processing but the performance eventually improves when she takes her time to perform the tasks. There are no clear abnormalities in the Luria test but the patient tends to occasionally perseverate. She has recall of 4 items after they have been presented to her 4 times 10 min prior. Calculation and constructional abilities are normal. Motor survey, motor strength, sensory exam, and reflexes were all normal.
She does not have papilledema. She is clearly overweight. There is some tenderness to palpation in the vertex but no clinical evidence suggestive of CSF leak.

IMPRESSION/REPORT/PLAN

1. Multifactorial headache
1 component of her headache might likely reflect analgesic overuse as the patient is taking over-the-counter medication daily for headache. The initial event after a head concussion appears to have been a migraine event. The headaches at the present time would be atypical for intracranial hypovolemia or CSF leak although a component of muscle contraction pain is also likely.

Recommendations
1. Discontinue daily use of Tylenol and avoid taking over-the-counter medication for headache more than twice a week for more than 15 days a month
2. Continue on the current dose of topiramate on the assumption that this medication is not make her brain rehabilitation more difficult, which I doubt
3. Overnight oximetry to look for possibility of sleep apnea. The patient has experienced some lapses in attention during the day which could raise the unlikely possibility of seizures and most likely reflect sleep intrusions
4. EEG overnight oximetry is normal, an EEG would be appropriate but I doubt it is going to show any epileptiform activity \
5. Engage into a regular exercise program
6. From the neurological standpoint, I see no contraindication for the patient to exercise or to fly

Discussed with the patient and her sister
I provided the patient with my card so her local physician can contact me if there is any question regarding my recommendations and for follow-up should she show any evidence of seizure activity

PATIENT EDUCATION
Ready to learn, no apparent learning barriers were identified; learning preferences include listening.
Explained diagnosis and treatment plan; patient expressed understanding of the content.

DIAGNOSES

#1 Multifactorial headache

Original: eeb/clb revised by eeb
Electronically Signed: 11-Jan-2018 14:21 by E.E. Benarroch, MD

10-Jan-2018 - Subsequent Visit, John L. D. Atkinson, Neurosurgery

REFERRAL
Dana Erickson, M.D. (4-7946).

HISTORY OF PRESENT ILLNESS
This patient is referred by Dr. Erickson, but she had called our office requesting an evaluation, given the symptoms she describes.

IMPRESSION/REPORT/PLAN
I reviewed Dr. Erickson's careful analysis of her symptoms. It is, as before, I have no surgical explanation for the symptoms she harbors, and the imaging, read here by neuroradiology, is unchanged for what is likely a Rathke's cyst which is unchanged from 2012 to the present.

I emphasized to the patient and her friend, both present in the room, that the cyst has nothing to do with her symptoms, will never any surgery (at least based on its past history of imaging over the last five years), and I have nothing to offer her. All questions were answered, there were no barriers to our discussion, and the patient and her friend fully understand.

Original: jla/sjv
Electronically Signed: 11-Jan-2018 13:18 by J.L. Atkinson, MD

10-Jan-2018 - Limited Evaluation, Dana Erickson, Endocrinology

REFERRAL
Return Visit

SYSTEMS REVIEW
PAIN SCALE
Patient's pain was reported using the numeric pain scale. Patient/caregiver rates pain at 0/10.

TOBACCO STATUS
Cigarette/Tobacco Use: Patient/caregiver reports no history of tobacco use.

WEIGHT MANAGEMENT
Weight management information provided to the patient/caregiver (MC7027).

VITAL SIGNS
Height: 181 cm. Weight: 131.8 kg. BSA(G): 2.4782 M2. BMI: 40.23 KG/M2. (10-Jan-2018 10:52)

IMPRESSION/REPORT/PLAN
ADVANCE DIRECTIVES
Patient does not have an Advance Directive at Mayo Clinic in Rochester, MN and is not interested in more information.

Original: de/skf revised by de
Electronically Signed: 16-Jan-2018 08:42 by D.. Erickson, MD